SelectAccount®

☐ ✔ if this is a resubmission ☐ ✔ if new address

HEALTH SAVINGS ACCOUNT WITHDRAWAL REQUEST

Used for requesting distributions from a Health Savings Account, not to exceed the available balance.

Complete when faxing: # of pages _____

To expedite reimbursement, fax this form to 1-866-231-0214. This form serves as the cover page.

For faster reimbursement submit online at **www.selectaccount.com.**

ACCOUNT HOLDER'S NAME AND ADDRESS	SelectAccount ID #
Last Name _____ First Name _____ Middle Initial _____	S A
Street Address _____	**Social Security #** (if SA# is not known)
City _____ State _____ Zip _____	**Daytime Phone**
Email address _____	

DISTRIBUTION AMOUNT (Print clearly)

Distribution Amount Requested: $ _____.____

DISTRIBUTION REASON

I direct the custodian to make a distribution from my account for the following reason: (Distributions will default to reason #1 unless otherwise indicated)

☐ 1. **Normal Distribution –** Distributions for any reason other than removal of an excess contribution, death, disability or a prohibited transaction. (Includes distribution to spouse after year of death).

☐ 2. **Excess Contribution Removal –** If your contributions exceed the applicable maximum annual contribution limit, then you may request SelectAccount to withdraw the excess contributions and any net income attributable to such excess contributions.

☐ 3. **Disability –** You may take a distribution due to disability only if the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the condition will last continuously for at least 12 months or lead to your death. Disability distributions may be subject to ordinary income tax.

☐ 4. **Death (in year of death to any beneficiary, or after year of death to an estate) –** If you are requesting a distribution as a beneficiary, you must furnish proof to verify your entitlement to receive the distribution. Use this reason for all payments during the year of death and to an estate after the year of death.

☐ 5. **Death (after year of death distributions to any beneficiary other than estate or spouse) –** If you are requesting a distribution as a beneficiary, you must furnish proof to verify your entitlement to receive the distribution. Use this reason if you are requesting a distribution as a nonspouse beneficiary after the year of death. (See codes 1 and 4 for other possible after year of death situations).

☐ 6. **Prohibited Transaction –** If you are requesting a prohibited transaction as defined in IRC Section 4975(c), you may be subject to an IRS penalty. If the prohibited transaction is not corrected timely, an additional penalty may be imposed.

BENEFICIARY (or Former Spouse) INFORMATION – Please complete if you checked Distribution Reason 4 or 5.

Name _____ Address _____ SSN# _____

PAYMENT INFORMATION

I am not required to submit supporting documentation with my distribution request in order to receive a distribution from my account. My request will be processed according to the available balance in my account.

If I have requested a withdrawal which exceeds my available account balance, I understand any unpaid portion of my request will be pended and automatically paid as additional contributions are posted to my account for a period of 12 months.

I understand my distribution request will be processed and a check will be issued to me unless I have completed the Authorization for Direct Deposit form, in which case my distribution will be automatically deposited into my bank account.

SIGNATURE

I understand that I am fully responsible for any taxes or losses that are incurred with respect to this account. To my knowledge, all information provided above is complete and accurate.

_____ Account Holder or Beneficiary Signature

_____ Date

APPEAL RIGHTS

The Explanation of Processing Report explains how your claim was processed based upon the information submitted to us. You or your designated representative may appeal a denial, partial denial, or reduction of your claim by following our appeal procedures. You may contact customer service at 1-800-859-2144 or 651-662-5065 for an explanation of your appeal rights. If you disagree with our decision on your claim, you have the right to submit a written request for an appeal review to SelectAccount, P.O. Box 64193, St. Paul, MN 55164-0193. We can send you a form to file your appeal or you can obtain a copy of the appeal form at www.selectaccount.com. You have until the later of your plan's run out end date or 180 days from the date of this notice to file an appeal. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or contact our customer service department. You may also submit any documents, records, or other information that relates to your claim for benefits. Upon receipt of your request, we will provide a full and fair review of your appeal and a written notice of our decision either by letter or an explanation on the Explanation of Processing Report within 30 days.

If you are a member of a group plan that is subject to the Employee Retirement Income Security Act (ERISA), once you have exhausted our appeal process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.

QUALIFIED MEDICAL EXPENSES

Medical expenses include payments you make for the diagnosis, treatment, or prevention of disease or for treatment affecting any part or function of the body and the amounts you pay for transportation to get medical care.

It is possible that changes in the IRS rules can affect what is considered a qualified medical expense. In general, the medical expenses that are allowable deductions on your Federal Income Tax Return (IRC Section 213(d)) are also reimbursable expenses through your account. To view a list of qualified medical expenses, go to www.selectaccount.com or contact customer service at 651-662-5065 or 1-800-859-2144.

HOW TO SUBMIT A WITHDRAWAL REQUEST

For faster reimbursement submit online at **www.selectaccount.com.**

For paper submissions, fax **OR** mail (not both) a completed claim form. If the expense incurred is reimbursable by an insurance company, you must submit the expense to the insurance company first. **Keep documentation for your tax records.**

Be sure to provide all information requested on the form. If the form is incomplete or unsigned, your claim request will be delayed or denied.

Per IRS regulations, supporting documentation is not required with your withdrawal request. Keep documentation for your personal tax records.

Submission Tips

✔ Complete claim form using a dark pen (do not use a pencil).
✔ Do not use a highlighter on this form.
✔ Retain confirmation of successful fax transmission.

Withdrawal requests can be mailed, faxed or submitted online to:

SelectAccount
ATTN: Account Administrator
P.O. Box 64193
St. Paul, MN 55164-0193
FAX: 651-662-7247 / 1-866-231-0214

FORMS AVAILABLE:
www.selectaccount.com
or by calling
SelectAccount
Customer Service

CUSTOMER SERVICE:
651-662-5065
1-800-859-2144
7 am - 7 pm, M-F